MAJOR TRAUMA:
(RTS ≤ 10 or by EMT or Paramedic judgment)

Basic Philosophy:
Rapid transport to the appropriate receiving hospital, treatment enroute, and early notification of the base hospital are major pre-hospital contributions to trauma patient survival. **A maximum scene time of 10 minutes is desirable**.

1. Initial Assessment:

    a. Airway (including evaluation for and initiation of C-spine precautions).
        i. Suctioning/clearing of airway.
        ii. Oropharyngeal or Nasopharyngeal or Orotracheal route with Sellick maneuver and manual C-spine immobilization.
        iii. Cricothyrotomy if other methods are unsuccessful or contraindicated.

    b. Breathing:
        i. Administer high flow oxygen and assist ventilations as necessary (use Sellick maneuver).
        ii. **Evaluate for and decompress** tension pneumothorax if hypotensive or unable to ventilate.
        iii. **Evaluate for and appropriately dress** open or sucking chest wounds.
        iv. Evaluate for flail chest, **consider positive pressure ventilation** by BVM or BV-ETT.

    c. Circulation:
        i. Assess for signs of shock.
        ii. Control external hemorrhage.
        iii. Large bore **IV**'s enroute. TKO, unless bolus is ordered by on-line Medical Control.

    d. Disability:
        i. **Spinal Immobilization**.
        ii. Rapid neurological exam (AVPU).
        iii. Ongoing assessment.

2. **Contact Medical Control**

3. Medical Control Options:
    a. IV fluid bolus if tension pneumothorax or cardiac tamponade is suspected. Use fluids with caution in other hypotensive patients, as this may be harmful.
        c. Analgesics
        i. **Fentanyl** 25-200 micrograms I.V. titrate for pain control, (25-50 micrograms every 10-15 min. up to 200 micrograms.) (1 microgram/kg in children) or
        ii. **Morphine** 2-15 mg IV titrate for pain control

    c. Consider sedation